

Case Number:	CM15-0130061		
Date Assigned:	07/16/2015	Date of Injury:	02/14/2014
Decision Date:	08/18/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	07/06/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Oregon

Certification(s)/Specialty: Plastic Surgery, Hand Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 45 year old male, who sustained an industrial injury on 2/14/14. He reported injury to his left middle finger after it was crushed between two parts of a metal ladder. The injured worker was diagnosed as having osteoarthritis of the hand. Treatment to date has included a TENs unit, physical therapy, Lidoderm and Gabapentin. The last comprehensive history and physical was 9/30/14 by the orthopedic surgeon. As of the PR2 dated 6/1/15, the injured worker reports significant pain in spite of therapy and splinting. Objective findings include ankylosed in approximately 20 degrees of hyperextension and significant tenderness circumferentially at the distal interphalangeal joint. A recent x-ray shows complete erosion of the cartilage with bone-on-bone contact. The orthopedic surgeon recommended a fusion of the distal interphalangeal joint. The orthopedic surgeon requested a comprehensive history and physical.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Associated surgical service: 1 comprehensive H&P: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Surgery General Information and Ground Rules, California Official Medical Fee Schedule, pages 92-93.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) TWC, Low Back updated 5/15/15, Preoperative testing.

Decision rationale: ODG-TWC, Low Back updated 5/15/15 states: "Preoperative testing (e.g., chest radiography, electrocardiography, laboratory testing, urinalysis) is often performed before surgical procedures. These investigations can be helpful to stratify risk, direct anesthetic choices, and guide postoperative management, but often are obtained because of protocol rather than medical necessity. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Patients with signs or symptoms of active cardiovascular disease should be evaluated with appropriate testing, regardless of their preoperative status. Electrocardiography is recommended for patients undergoing high-risk surgery and those undergoing intermediate-risk surgery who have additional risk factors. Patients undergoing low-risk surgery do not require electrocardiography. Chest radiography is reasonable for patients at risk of postoperative pulmonary complications if the results would change perioperative management. Patients in their usual state of health who are undergoing cataract surgery do not require preoperative testing. (Feely, 2013) Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease, that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings. However, the relative effect on patient and surgical outcomes, as well as resource utilization, of these two approaches is unknown. (AHRQ, 2013) The latest AHRQ comparative effectiveness research on the benefits and harms of routine preoperative testing, concludes that, except for cataract surgery, there is insufficient evidence comparing routine and per-protocol testing." ODG guidelines support a complete history and physical for all patients prior to surgery. Therefore, this request is medically necessary.